

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

CECIL

City or town.....

PERRY POINT, MD.

(If outside city or town limits, write RURAL and give nearest town)

10 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution?

120 days

3. (a) FULL NAME

MOSES BLANCHARD

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

Unknown

7. Birth date of deceased (mo. day, yr.)

May 2, 1893

6. (c) If alive, give age..... years

8. AGE:

Years
54

Months
5

Days
23

If less than one day

hrs.

min.

9. Birthplace.....

Asheville, N.C.

(Town, county, and state)

10. Usual occupation

Ball Park Attendant

11. Industry or business

Unknown

MOTHER

FATHER

12. Name.....

Unknown

13. Birthplace

Unknown

14. Maiden name.....

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records

Address

VAH, Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Unknown

Date thereof.....

10-26-47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

Pennington & Son

Havre de Grace, Md.

19. Oct 26 1947 Jane E. Daugherty
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

North Carolina

County.....

Asheville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

51 Carroll Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 25

19. 47

6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 15

19. 47

to October 25 19. 47

and that I last saw him..... alive on

October 25

19. 47

Immediate cause of death

Uremia

Due to.....

due to Tabetic bladder

3 mos.

due to Central nervous system

Due to.....

syphilis

Duration over

10 years

Other conditions

Possible pneumonia-bronchitis

2 days

Tabetic bladder

107

Unknown

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

—

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

—

Means of injury

—

Injured at work

—

23. SIGNATURE

V. J. COVALESKY, M.D., Act. Clin. Director

Address

VAH, Perry Point, Md.

10-21-47

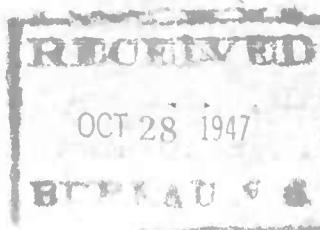
Date signed

GRANDMONT 8-1000

292

GRANDMONT

CA 220001



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

08959

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
 City or town Perry Point, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 13 days

Hospital, Institution, or street address where death occurred:

VA Hospital, Perry Point, Md.How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Port Deposit
 (If outside city or town limits, write RURAL and give nearest town)Street No. RT #1, Box #16

(If rural, give LOCATION)

2.(a) If veteran, name war WW-II

3.(a) FULL NAME

BROWN, Harry L.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>M</u>	<u>Negro</u>	<u>Single</u>

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo. day. yr.) Jan. 30, 1923

8. AGE: Years	Months	Days	If less than one day
<u>24</u>	<u>9</u>	<u>24</u>	hrs. _____ min. _____

9. Birthplace Rowlandsburg, Md.
 (Town, county, and state)10. Usual occupation Unknown

11. Industry or business

12. Name Raymond J. Brown, Sr.13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Hospital Records

Address

17. Burial Date thereof Oct. 30, 1947
 (Burial, cremation, or removal. Which?)Mt. Zoar Cemetery

Cemetery or crematory

Location Conowingo, Md.18. Funeral director J. EARL TYSONAddress Rising Sun, Maryland19. Oct. 27, 1947 Irene E. Edmondson
 (Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1947 at 7:55 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14, 1947 to Oct. 27, 1947, and that I last saw h. 1 m. alive on October 27, 1947.

Immediate cause of death

UremiaDue to Chronic glomerulonephritisApprox. 1 yr. DURATION 3 months

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

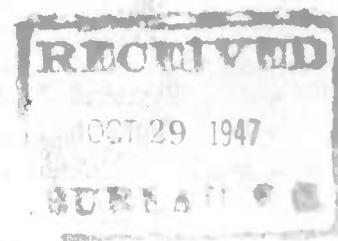
Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

V. J. COVALESKY, M.D., Acting Clin. Director
 VAH, Perry Point, Md. Date signed 10-27-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 68361694

1. PLACE OF DEATH: Cecil
 County: North East Rural

City or town: North East Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Arrie H. Burns

4. Sex: Female 5. Color or race: white 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Harry Burns

7. Birth date of deceased (mo., day, yr.): April 15 1861 8. (c) If alive, give age: 80 years

8. AGE: 76 Years 5 Months 18 Days If less than one day: hrs. min.

9. Birthplace: Cecil Co Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

12. Name: William Nowland 13. Birthplace: Maryland

14. Maiden name: Marry Matthews 15. Birthplace: Maryland

16. Informant: Harry Burns 17. Address: North East Md

Burial: Burial Date thereof: Oct 6, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Methodist Location: Bay View Md

18. Funeral director: Joseph P. Grant Address: North East

19. (a) Date rec'd by registrar: 10-6 1947 (b) Address: Leda & Irene

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number:

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 Oct. 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Oct. 1947

and that I last saw her alive on 3 Oct. 1947.

Immediate cause of death: Cerebral Hemorrhage DURATION 1 hour

Due to: Generalized Arteriosclerosis DURATION 25 years

Due to: Essential Hypertension DURATION 25 years

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

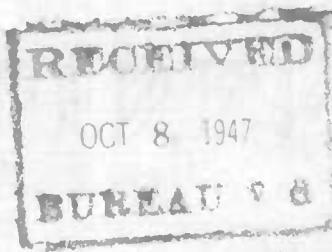
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Plans H. Huebner M.D. M. D. or other:

Address: North East, Md Date signed: 4 Oct. 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 68961 92

1. PLACE OF DEATH: Cecil
 County: Perryville
 City or town: Perryville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Cecil
 City or town: Perryville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)
 2.(a) If veteran, name war:

3. (a) FULL NAME Mary Anna Burroughs
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Ormond R. Burroughs
 7. Birth date of deceased (mo., day, yr.) June 9, 1919 8. (c) If alive, give age 29 years
 8. AGE: Years 28 Months 4 Days 22 If less than one day hrs. min.
 9. Birthplace Perryville, Cecil Co., Md.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business
 12. Name George L. Alexander
 13. Birthplace Perryville, Md.
 14. Maiden name Edith Patterson
 15. Birthplace Perryville, Md.
 16. Informant Ormond R. Burroughs Jr.
 Address Perryville, Md.

17. Burial Burial Date thereof Nov. 3 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Asbury
 Location Port Deposit, Md. Rural
 18. Funeral director Red Patterson
 Address Perryville, Md.
 19. Nov. 1, 1947 James E. Daugherty
 (Date rec'd by registrar) Registrar

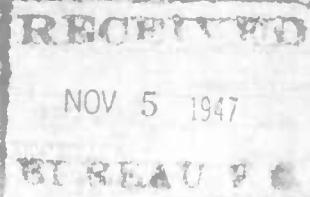
3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 31 1947 at 4 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1st to 31 1947 to October 31 1947 and that I last saw her alive on October 31 1947

Immediate cause of death Acute Radiation of Heart

Due to <u>Chronic Valvular Heart Disease</u>	DURATION <u>1 day</u>
Due to	20
Other conditions	
(Include pregnancy within 3 months of death)	
Major findings of operations	
Date of op.	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide..... Date of.....	
Where did injury occur?..... (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?).....	
Means of injury..... Injured at work?	
23. SIGNATURE <u>J. F. Magrath</u>	
M. D. or other	
Address <u>Perryville, Md.</u> Date signed <u>Nov. 1 1947</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

68962

96

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

(Burrows)

8. (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.)

Sept 4 1910

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

MOTHER FATHER

Alfonso R Burrows.

Pentico. pleel.

13. Birthplace.....

Mary & Redgrave

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 14 1947 at 350P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

10.....

and that I last saw h. alive on

19.....

Immediately cause of death.....

Compressed.
Fracture of skull
with loss of
Due to. brain tissue.

DURATION

Due to.....

Due to. brain tissue.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Industry

Injured at work?

Yes

Address.....

Address.....

23. SIGNATURE

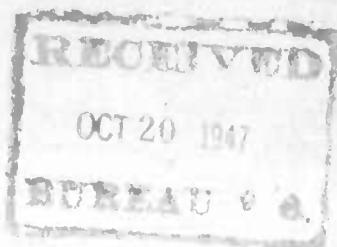
Signature.....

M. D. or other

Address.....

Address.....

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If any item is especially important, Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

68963

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH

County

City or town

Decil
Cecilton Rural

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 29 - 1928

years

8. AGE:

Years

Month

Days

If less than one day

hrs.

min.

9. Birthplace

Penn.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Auto service man

12. Name

John H. Carlin Jr.

13. Birthplace

Pa.

14. Maiden name

Cecilia Kincaid

15. Birthplace

Virginia

16. Informant

John H. Kincaid

Address

Dover Delaware

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof 10-18-47
(month) (day) (year)

Cemetery or mortuary

Lake Side Cemetery

Location

Dover Delaware

18. Funeral director

G. Fisher Daniel

Address

Middletown Del

19. (Date rec'd by registrar)

Oct 16 1947

Mrs. Harriet W. Cheyney

Registered Address

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State

Del.

County

Kent

City or town

Dover

(If outside city or town limits, write RURAL and give nearest town)

Street No.

226

Middletown Del

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 16 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

19.

and that I last saw h. alive on

19.

Immediate cause of death

Cornhound
forgetting
of smell.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 10/16/47

Where did Injury Cecilton Del. (City or town) (County) (State)

Injured at home, farm, industry, public place (where) Death at home

Means of injury Automobile Injured at work

Medical Examiner

Pleasanton Del. for Cecil County

M. D. or other

Date signed 10/16/47

RECEIVED

OCT 18 1947

RENTAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08964

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **Cecil**City or town..... **Port Deposit**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **50 Yrs.**

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Nettie M. Creamer4. Sex..... **Female** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Widowed**8. (b) Name of husband or wife..... **Harry C. Creamer**7. Birth date of deceased (mo., day, yr.)..... **April 13, 1861** 6. (c) If alive, give age..... years8. AGE: Years..... **86** Months..... **5** Days..... **25** If less than one day..... hrs..... min.....9. Birthplace..... **Baltimore, Md.** (Town, county, and state)10. Usual occupation..... **House Wife**

11. Industry or business

12. Name..... **John A. Mitchell**13. Birthplace..... **Harford Co., Md.**14. Maiden name..... **Addie** White15. Birthplace..... **Cecil Co., Md.**16. Informant..... **Mrs. A. James Roe.**Address..... **Port Deposit, Md.**17. Burial..... **Burial** Date thereof..... **Oct. 11, 1947** (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... **Hopewell**Location..... **Port Deposit, Md. Rural**18. Funeral director..... **S. A. Patterson & Son**Address..... **Terryville, Md.**19. Date rec'd by registrar..... **Oct. 11, 1947** (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Cecil**City or town..... **Port Deposit**

(If outside city or town limits, write RURAL and give nearest town)

Street No..... **50 S. Main**

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October - 8** 1947 at 3 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **May 10, 1947** to **Oct 8 - 1947** and that I last saw **h.s.** alive on **Oct 8 - 1947**

Immediate cause of death.....

Coronary Occlusion -

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE..... **B. J. Benson, M.D.**

M. D. or other

Address..... **Port Deposit, Md.**Date signed **10/19/47**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08965
138

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL

City or town PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

18 yrs. 11 mos. 12 das.

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Maryland

How long in hospital or institution?

28 yrs. 7 mos. 9 das.

3. (a) FULL NAME

ROCCO DANZIG

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Unknown

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1893

6. (c) If alive, give age years

8. AGE:

Years 54

Months Unkwn

Days Unkwn

It less than one day

hrs. min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Unknown - Deceased

13. Birthplace

Italy

14. Maiden name

Unknown - Deceased

15. Birthplace

Italy

16. Informant

Hospital Records

Address

VAH, Perry Point, Maryland

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 10-2-47

(month) (day) (year)

Cemetery or crematory

St. Peters Cemetery

Location

Staten Island, New York

18. Funeral director

Panninger & Son

Address

Havre de Grace, Maryland

19. Oct. 2

19-47

Dene E. Daugherty

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York

County

Richmond

City or town New Brighten, Staten Island

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

World War I

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 1

19-47

at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 19-28 to October 1 19-47

and that I last saw him alive on October 1 19-47

Immediate cause of death

Tuberculosis, pulmonary, chronic, far advanced, active

DURATION

over 20 years

Due to

Due to

Other conditions Dementia Praecox, Catatonic Type

(Include pregnancy within 3 months of death)

29 years

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

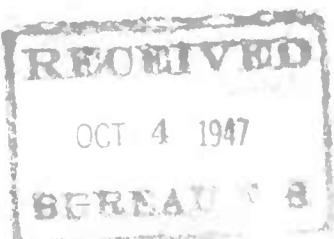
Misses of injury

Injured at work

23. SIGNATURE

A.E. TROLLINGER, M.D., Clin. Director

VAH, Perry Point, Md. Date signed 10-2-47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08967

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL

City or town PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 8 mos. 23 das.

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution? 28 years

3. (a) FULL NAME

JOHN B. GIGUERE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

August 27, 1888

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59

1

8

hrs. min.

9. Birthplace

Fairview, Massachusetts

(Town, county, and state)

10. Usual occupation

Printer

11. Industry or business

12. Name Unknown - Deceased

13. Birthplace Unknown

14. Maiden name Unknown - Deceased

15. Birthplace Unknown

16. Informant Hospital Records

Address VAH, Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof October 9, 1947

(month) (day) (year)

Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director

Pennington & Son

Address Havre de Grace, Md.

19. (Date rec'd by registrar)

1947

Irene E. Daugherty

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MASSACHUSETTS County Hampden

City or town Holyoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 342 Main Street

(If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5

1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12

1945 to October 5, 1947

and that I last saw him alive on October 5

1947

Immediate cause of death

Arteriosclerotic coronary heart disease

DURATION

Unknwn

Due to

Due to

Other conditions Arteriosclerosis, generalized

(Include pregnancy within 3 months of death)

Unknwn

Major findings or operations

Date of op.

Autopsy results Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

A. E. TROLLINGER, M.D., Clinic Director

VAH, Perry Point, Md.

Date signed 10-7-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

08968

CERTIFICATE OF DEATH

Re Reg. Dist. No. 96

1. PLACE OF DEATH:

County **CECIL**City or town **PERRY POINT, MARYLAND**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **2 years 11 mos. 3 das.**

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.How long in hospital or institution? **29 years**

3. (a) FULL NAME

SOLOMON GOLDSTEIN

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Syd Spira**Deceased**

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

March 11, 1894

8. AGE:

53

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

MOTHER FATHER

Nathan Goldstein

13. Birthplace

Russia

14. Maiden name

SCHERR

15. Birthplace

RUSSIA

16. Informant

Hospital Records

Address

VAH, Perry Point, Md.

17. Removal

Date thereof **10-21-47**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory **Hebrew Friendship Cemetery**

Location

Baltimore, Maryland

18. Funeral director

Sol. Levinson BrosAddress **Solomon Levinson & Brothers****1124 W. North Ave., Baltimore, Md.**19. *10/21***19-47***Issue 5-24-47*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **MARYLAND**

County

BALTIMORECity or town **BALTIMORE**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **3530 Reisterstown Road**

(If rural, give LOCATION)

2.(a) If veteran, name war **WW-I**

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

October 21**19 47****at 2:40 A.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 18****19 44** to **October 21** **19 47**and that I last saw him alive on **October 21** **19 47**

Immediate cause of death

Bronchopneumonia

DURATION

2 days

Due to

Due to

Other conditions **Manic depressive psychosis****29 years**

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results **No autopsy**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

V.J. COVALESKY, M.D., CLINIC DIRECTOR (ACTG)**VAH, Perry Point, Md.****Date signed 10-21-47**

RECD

OCT 22 1947

BUREAU

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68969
95

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Cecil

City or town

Liberty Grove

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

43 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Blanche Ethel Grist

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Howard Grist

6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.)

Aug. 26, 1883

8. AGE:

Years

64

Months

2

Days

4

If less than one day

hrs.

min.

9. Birthplace

Berkley

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

John Smith

13. Birthplace

Md.

14. Maiden name

Sarah McHatt

15. Birthplace

Md.

16. Informant

Howard Grist

Liberty Grove Md.

Address

Date thereof: Oct 2 1947

(month) (day) (year)

17. Burial

(Burial, cremation, or removal. Which?)

West Baltimore

Cemetery or crematory

Columbia Md.

Location

J. G. Tysor

18. Funeral director

Address

Rising Sun Md.

19. (If death rec'd by registrar)

Nov 1-47 Lawrence Washington

Cemetery

Cemetery

Date

11-1-47

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.

County

Cecil

City or town: Liberty Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

10-30

1947 at 4:34 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

9-10

1946 to 10-30 1947

and that I last saw her alive on

10-29

1947

Immediate cause of death

Gastric Hemorrhage

DURATION

Accident

Due to Myocarditis chronic & Hypertensive Cardiovascular disease

10 yrs

Due to Hyperthyroid

2 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

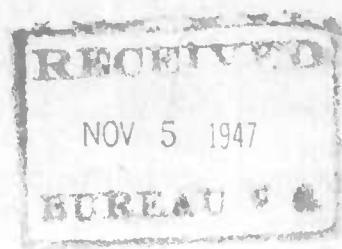
Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address: Fort Deposit, Md. Date signed: 11-1-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08970

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
City or town Elkton R D (Fair Hill) MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 yrs
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William H Hamilton

4. Sex

Male white married
8. (b) Name of husband or wife Reba M Hamilton

7. Birth date of deceased (mo., day, yr.)

March 24 1871

6. (c) If alive, give age years

8. AGE:

Years <u>76</u>	Months <u>6</u>	Days <u>16</u>	If less than one day hrs. <u>0</u> min. <u>0</u>
-----------------	-----------------	----------------	---

9. Birthplace

West Newton Pa

(Town, county, and state)

10. Usual occupation

Plumber

11. Industry or business

James Hamilton

12. Name

James Hamilton

13. Birthplace

Ireland

14. Maiden name

Priscilla Rollins

15. Birthplace

West Newton Pa

16. Informant

Mabel Bouchard

Address

Elkton MD

17. Burial

(Burial, cremation, or removal, Which?) Burial Date thereof Oct 14 1947
(month) (day) (year)

Cemetery or crematory

Sharks Cemetery

Location

Fair Hill Maryland

18. Funeral director

Stevens

Address

Elkton MD

19. Oct 14 1947
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
City or town Elkton and RD Fair Hill MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fair Hill MD
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

213-05-3990

MEDICAL CERTIFICATION

2D. DATE OF DEATH

10 October 1947 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

10 October 1947 to 10 October 1947

and that I last saw him alive on 10 October 1947

Immediate cause of death

Heart Failure

DURATION

48 hours

Due to Hypertension and arteriosclerosisStrokeDue to Lower Pneumonia (Post)Other conditions Arteriosclerosis

arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George Klein, Jr M.D. or otherAddress Elkton, Md.Date signed Oct 14 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1610

CERTIFICATE OF DEATH

Reg. Dist. No. 91

68971

1. PLACE OF DEATH:
Cecil
County.....

City or town..... Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Union Hospital of Cecil County

How long in hospital or institution?

3. (a) FULL NAME

Carol Lee Hutchison

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)
October 24, 1947

8. AGE: Years	Months	Days	If less than one day
		2	hrs. min.

9. Birthplace..... Elkton, Cecil Co., Maryland
(Town, county, and state)

10. Usual occupation..... Newborn infant

11. Industry or business.....

12. Name..... George Thomas Hutchison

MOTHER FATHER 13. Birthplace..... Delaware City, Delaware

14. Maiden name..... Lulu Louise Mc Kelvey

15. Birthplace..... Baltimore County, Md.

16. Informant..... Lulu Hutchison

Address..... 131 Maffett Street

17. Burial..... Date thereof..... Oct 27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Bethel

Location..... Near Chesapeake City, Md

18. Funeral director..... Hot Lipspey

Address..... Elkton, Md

19. Oct 27 1947 Date rec'd by registrar..... F. R. Frazer

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 131 Maffett Street
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 27/47

21. I CERTIFY that death occurred as the date above stated; that I attended deceased from

Oct. 24 1947 to Oct. 27 1947

and that I last saw her alive on Oct. 26 1947

Immediate cause of death..... Enythoblastosis foetalis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury..... Injured at work?

23. SIGNATURE..... Dr. Edward H. Sprecher

M. D. or other..... M.D.

Date signed..... Oct 27/47

Address..... Elkton, Md

RECEIVED

OCT 29 1947

BUBYAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08972

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
County: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 5 hoursHospital, institution, or street address where death occurred:
Union Hospital of Cecil CoHow long in hospital or institution? 5 hours

3. (a) FULL NAME

Irene Lynch4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
8. (c) If alive, give age..... years8. AGE: Years 4 Months hr. 45 Days 45 If less than one day 45 hrs. 45 min.9. Birthplace Union Hospital Elkton
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Alvin Crisfield Lynch13. Birthplace Middletown Delaware14. Maiden name Mary Coulter Speakman15. Birthplace Cochranville, Pa.16. Informant Alvin C. LynchAddress Elmwood Manor, Elkton
Burial Elkton Date thereof Oct 27/47
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Elkton
Location Elkton, Md.18. Funeral director H.W. Pipkin
Address Elkton, Md.19. Oct 27 1947 J.R. Traeger
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County New CastleCity or town Elsmere Manor Wilmington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1036 Dover Elkton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1947 at 9 1/2 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25 1947 to Oct. 25 1947and that I last saw her alive on Oct. 25 1947

Immediate cause of death

Pneumonia (2.8 wks.)

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury

Injured at work?

23. SIGNATURE Donald W. SpealerM. D. or other XAddress Elkton, Maryland Date signed Oct 26/47

RECEIVED

OCT 29 1947

BUREAU of

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08973

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH: *Cecil*
 County: *Lombard*
 City or town: *Maryland* (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *Many years*
 Hospital, Institution, or street address where death occurred: *At home*

How long in hospital or institution?

3. (a) FULL NAME

Elphonsa Kirk Martindelle

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6. (b) Name of husband or wife: *Walter Martindelle*

7. Birth date of deceased (mo., day, yr.) *Jan 19 1874*
 6. (c) If alive, give age *75* years

8. AGE: Years *73* Months Days It less than one day
 hrs. min.

9. Birthplace: *Maryland*
 (Town, county, and state)

10. Usual occupation: *Housewife*

11. Industry or business:

12. Name: *William B. Kirk*
 13. Birthplace: *Maryland*

14. Maiden name: *Lillie Ewing*

15. Birthplace: *Maryland*
 16. Informant: *Walter Martindelle*

Address: *Nottingham R.D.*
 17. Burial: *Burial* Date thereof: *Oct, 11-1947*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: *Rose Bank Calvert Md.*
 Location: *Near Rising Sun.*

18. Funeral director: *J. E. Tyson*
 Address: *Rising Sun Md.*

19. (Date rec'd by registrar) *Oct 8-47* Address: *2 Nottingham*
 Registrar: *552*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Maryland* County: *Cecil*
 City or town: *Nottingham Penna* (If outside city or town limits, write RURAL and give nearest town)
 Street No.: *Lombard* Maryland (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: *October 8 1947*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
 19 to 20 Oct 8 1947
 and that I last saw her alive on Oct 8 1947

Immediate cause of death: *Congestive Heart Failure*
 Due to: *Arteriosclerosis*

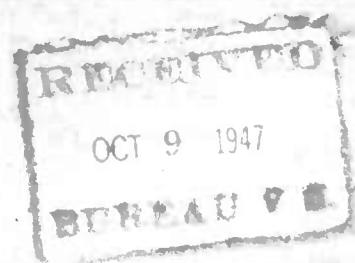
Due to: *Intra abdominal malignancy with mediastinal metastases*
 (Include pregnancy within 8 months of death)

Other conditions:
 Major findings of operations: Ante mortem results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury: Injured at work? 23. SIGNATURE: *J. B. Robinson M.D.* M. D. or other: Address: Date signed:



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

08974

1. PLACE OF DEATH:

County

Rural near Elkhorn, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 years

Hospital, institution, or street address where death occurred:

R.D. 1

How long in hospital or institution?

3. (a) FULL NAME

DeBaux McKee

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M wh Married

6.(b) Name of husband or wife

Bonnie H. McKee

6.(c) If alive, give age

68 years

7. Birth date of

deceased (mo., day, yr.)

May 12, 1875

8. AGE:

Years

Months

Days

If less than one day

72 5 10 hrs. min.

9. Birthplace

(Town, county, and state)

Tenn.

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Milford F. McKee

13. Birthplace

Tenn.

MOTHER FATHER

14. Maiden name

Lorraine Thompson

15. Birthplace

Tenn.

16. Informant

Mrs. Sara M. Cooke

Address

Elkhorn R.D. 1, Md.

Cremation

Date thereof Oct 23/47

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Silverbrook Crematory

Location

Wilmington, Del.

18. Funeral director

H. L. Sprecher

Address

Elkhorn, Md.

19. Date rec'd by registrar

Oct 23 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Cecil.

City or town

Rural near Elkhorn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

R.D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

121-16-8923

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 22 1947 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1947 to Oct. 22 1947

and that I last saw her alive on

Immediate cause of death

Carcinoma of Larynx

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Ca. of Larynx

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Orlando F. Sprecher

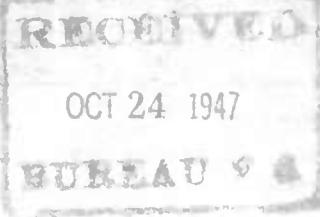
M. D. or other

Address

Elkhorn, Md.

Date signed

Oct 22 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

08975

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County

CECIL

City or town

PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

11 mos. 22 das.

How long in above place of death?

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Maryland

How long in hospital or institution?

About 2 years

3. (a) FULL NAME

JOHN L. MC KENNEY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

December 27, 1869

8. AGE:

Years	Months	Days	If less than one day		
77	9	5	hrs.	min.	

9. Birthplace

(Town, county, and state)

Mass.

10. Usual occupation

Retired

11. Industry or business

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records

Address

VAH, Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

10-3-47 (month) (day) (year)

Cemetery or crematory

Arlington National Cemetery

Location

Washington, D.C.

18. Funeral director

Pennington & Son

Address

Havre de Grace, Md.

19. Date rec'd by registrar

Oct 3 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

City or town

Takoma Park

Street No.

29 Carroll Avenue

(If rural, give LOCATION)

World War I

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 2

19 47, at 6:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 10

19 46

to Oct. 2 19 47

and that I last saw him alive on

October 2

19 47

Immediate cause of death

Uremia

DURATION

10 days

Due to

Nephrosclerosis

Unknown

Due to

Other conditions

Arteriosclerotic heart disease
& Ulcerative colitis, non-specific.

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

A.E. TROLLINGER, M.D., Clin. Director

VAH, Perry Point, Md.

Date signed Oct 23 1947

RECEIVED

OCT 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

836

08976

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH

County

City or town

Cecil

Carrollville

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

George P. Moffett

6. (c) If alive, give age

73 years

7. Birth date of deceased (mo., day, yr.)

July 7 1878

8. AGE:

Years

69

Months

Days

It less than one day

hrs. min.

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Edward L. McGowen

12. Name

Pa.

13. Birthplace

Philadelphia, Pa.

14. Maiden name

Anna J. Kelly

15. Birthplace

Philadelphia, Pa.

16. Informant

George P. Moffett

Burial

Cemetery or crematory

Old Bohemia

Location

near Warwick, Md.

18. Funeral director

Edward Bellour

Address

Millington, Md.

19. 10-10-47 1947

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

Street No.

Address

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Oct 8 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

November 1946 to Oct 8 1947

and that I last saw her alive on Oct 8 1947

Immediate cause of death: Cerebral

thrombosis and embolism

DURATION 6 hours

Due to:

Due to:

Other conditions:

Generalized arteriosclerosis years

Senility & emaciation

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

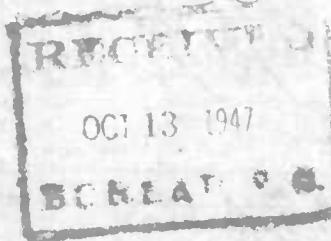
23. SIGNATURE

M. D. or other

Address Date signed

Signature

Address Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68977

CERTIFICATE OF DEATH

Reg. Dist. No.

96

95c

1. PLACE OF DEATH:

County

City or town

Cecil
Rising Sun Rural.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Florence May Montgomery

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F Blue Marie d
Harry Montgomery

6. (b) Name of husband or wife

6. (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.)

April 26 1878

8. AGE:

Years 69

Months 5

Days 20

If less than one day hrs. min.

9. Birthplace

Port Deposit Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Samuel T Harris

Port Deposit Md.

Hannah Porter

Port Deposit Md.

Mrs H. Ryan

Address Rising Sun Md.

Burial Date thereof Oct. 19 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Nottingham

Location Colona, Md. Rural

Funeral director Lee A. Patterson & Son

Address Perryville, Md.

Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Cecil

County

Rising Sun Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19.

and that I last saw h. alive on

Immediate cause of death Chronic Hypertension and Cardiac Decompensation

Due to Chronic Coronary

sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lee A. Patterson & Son, Inc. Medical Examiner

Cecil County, Md. D. or other

Address Rising Sun Md. Date signed 10-16-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 108928

1. PLACE OF DEATH:

County.....

Lacul

City or town.....

Elekton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 day

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?.....

1 day

3. (a) FULL NAME

Alice Lucy Nash

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white widowed

6. (b) Name of husband or wife

Edward C. Nash

7. Birth date of deceased (mo., day, yr.)

May 30 - 1869

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Fairfax Vermont

(Town, county, and state)

10. Usual occupation.....

Phone

11. Industry or business

Samuel Wilson

MOTHER FATHER

12. Name.....

Lemont

13. Birthplace

Lemont

14. Maiden name.....

Leontine Stelloff

15. Birthplace

Lemont

16. Informant.....

Beatrice Almour

Address

North East - Md Rd.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Fairfax cemetery

Location

St Albans Vermont

18. Funeral director

Joseph R. Grant

Address

North East Maryland

19. Oct 6 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 5 -

1947 at 9:10P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 4 et

1947 to Oct 5 - 1947

and that I last saw h. 25 alive on

Oct 5 - 1947

Immediate cause of death

Cerebral hemorrhage

DURATION

about 12 hrs

Due to

Senile dementia

unknown

Due to

Hypertension with

unknown

general arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

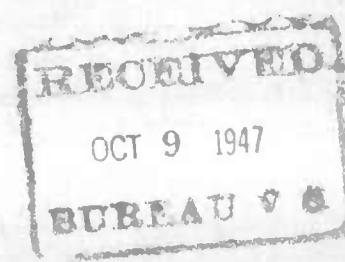
J. H. McNight

M. D. or other

Address

Elekton - Md

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 96

AC 08979
96

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

CECIL

County

PERRY POINT, MARYLAND

City or town

(If outside city or town limits, write RURAL and give nearest town)

19 yrs. 6 mos. 22 das.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

VAH, Perry Point, Maryland

How long in hospital or institution?

About 21 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

BALTIMORE

City or town

BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

508 S. Streeter Street

(If rural, give LOCATION)

2.(a) If veteran, name war

World War I

3.(a) FULL NAME

JOSEPH RAPHAEL NOLAN

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

Single

6.(b) Name of husband or wife

—

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

December 28, 1893

8. AGE:

Years

Months

Days

If less than one day

53

9

4

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Switchboard Operator

11. Industry or business

MOTHER FATHER

Edward R. Nolan

13. Birthplace

Maryland

14. Maiden name

Beza Coyne Nolan

15. Birthplace

Maryland

16. Informant

Hospital Records

Address

VAH, Perry Point, Md.

17. Removal

Date thereof October 3, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Baltimore National Cemetery

Cemetery or crematory

Baltimore, Maryland

18. Funeral director

P. J. Trolling

Address

Havre de Grace, Maryland

19. Date rec'd by registrar

19-47

Date rec'd by registrar

19-47

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 2 1947 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 1928, to Oct. 2, 1947,

and that I last saw him alive on October 2, 1947.

Immediate cause of death

Bronchopneumonia, terminal

DURATION

5 days

Due to Encephalitis lethargica,

Parkinsonian syndrome

over 25 years

Due to

Uremia

Arteriosclerosis, generalized

(Include pregnancy within 3 months of death)

approx. 1 m.o.

Unknown

Major findings or operations

Date of op.

Confirms above

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

A. E. TROLLINGER, M.D. Director

VAH, Perry Point, Md. Date signed 10-3-47

1000

1000

1000

1000

RECEIVED

OCT 9 1917

BUREAU 9 C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

469

68980

Reg. Dist. No. 92

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Cecil

City or town

Elkton, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Tumor

Stay in hospital or Inst. (yrs., or mos., or days)

5 days

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Angelia Onizuk

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. Wh. Married

6 (b) Name of husband or wife

Andrew Onizuk

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

Aug 28, 1888

8. AGE: Years

Months

Days

If less than one day

59

2

29

hrs.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

at Home

11. Industry or business

MOTHER FATHER

Louis Tokar

12. Name

Poland

13. Birthplace

Tadeusz Sminiski

14. Maiden name

Poland

15. Birthplace

Andrew Onizuk

16. Informant

Elkton R.O. 3, Md

17. Burial

Oct 27/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Catholic

Location

Elkton, Md

18. Funeral director

H. W. Pappin

Address

Elkton, Md

19. Oct 27 1947

H. F. Fraser

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

County

Cecil.

City or town

Rural near Elkton

Ward No.

Street No.

R. D. 3

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 25 1947 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 22 1947 to October 25 1947,

end that I last saw her alive on October 24 1947.

Immediate cause of death

Obstruction of common bile duct
(Probable) Carcinoma of Pancreas.

DURATION

5 days

return

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

None

Df operations

Df autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henry Doris M.D.

M. D. or other

Address

Chesterfield City, Md

Date signed

RECEIVED

OCT 29 1947

FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68981

CERTIFICATE OF DEATH

1648
96
Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M White married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years
52. 6Months
23Days
If less than one day

hrs. min.

9. Birthplace

New York N.Y.

(Town, county, and state)

10. Usual occupation

Secretary

Slow business

Business

11. Industry or business

Business

MOTHER FATHER

12. Name

Harry Paer

Business

13. Birthplace

Russia

Russia

14. Maiden name

Rebecca Sanders

Russia

15. Birthplace

Russia

Russia

16. Informant

Sam Paer

110-35 72 Rd Forest Hill

Long Island

Removal

Date thereof

Oct. 28, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

To Riverside Memorial Chapel

Cemetery or crematory

Amsterdam Ave. & 76th St. New York

Location

N.Y.

Lew A. Patterson & Son

Funeral director

Address Perryville, Md.

VS A15 9-45-15M

18. Date rec'd by registrar

Oct. 28, 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Florida County Dade

City or town Miami Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6918 Bay Drive

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

109-16-8814

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1947

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to.

and that I last saw him alive on

Immediate cause of death

Fractured neck

Fractured left

arm.

Accelerated death

Due to pneumonia

contagious

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide or homicide

Date of 10-27-47

Where did injury occur

(City or town) Perryville, Md.

(County) Cecil County

(State) Md.

Injured at home, farm, industry, public place (where?)

Means of injury

P.P. Paer

Injured at work?

Medical Examiner

Dr. Dockson, M.D.

Cecil County

M. D. or other

Date signed 10-27-47

Address Perryville, Md.

RECEIVED

OCT 30 1947

BUREAU of

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316 08982

95

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Cecil
Rising Sun.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Marshall Hartshorn Pierce

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

B. (b) Name of husband or wife

Mary Pierce

7. Birth date of deceased (mo., day, yr.)

April 13, 1867

6. (c) If alive, give age 78 years

8. AGE:

Years 80 Months 6 Days 14 It less than one day hrs. min.

9. Birthplace

Rising Sun Cecil Co. Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

William C. Pierce

FATHER

12. Name

Island

13. Birthplace

Sarah Rogers

14. Maiden name

Md.

15. Birthplace

Rising Sun

16. Informant

Mrs. Mary Pierce

Address

Rising Sun Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 31 1947

(month) (day) (year)

Cemetery or crematory

Brookview

Location

Rising Sun Md.

18. Funeral director

J. E. Tyson

Address

Rising Sun Md.

Date reg'd by registrar Oct. 29 1947

Date signed Oct. 29 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Cecil

City or town

Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

.....

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 27 1947 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw h..... alive on

Immediate cause of death

Chronic myocarditis
& Cerebral
Inflammation

Due to

.....

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

R. E. Dodson M.D. Medical Examiner

Cecil County, Md. or other

Address Rising Sun Md. Date signed Oct. 29-47

RECEIVED

OCT 31 1947

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68983

95c

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

Cecil
Ecclesian Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

White

Single

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

Feb. 22. 1857.

(c) If alive, give age

years

8. AGE:

Years
90Months
8Days
18

If less than one day

hrs. min.

9. Birthplace

Reserve Sun. Md.

(Town, county, and state)

10. Usual occupation

Dowse

11. Industry or business

Robert Rinks

12. Name

Pa.

13. Birthplace

Rebecca Braxton

14. Maiden name

Leolara

15. Birthplace

Md.

16. Informant

Gra. Barron.

Address

Childs Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)

West Nottingham Friends

Cemetery or crematory

New Colora Md.

Location

E. Tyson

18. Funeral director

Rising Sun. Md.

Address

Oct. 15 1947

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

October 11 1947 at 10.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to

19.

and that I last saw h. alive on

Immediate cause of death

Acute dilatation
of heart

19.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

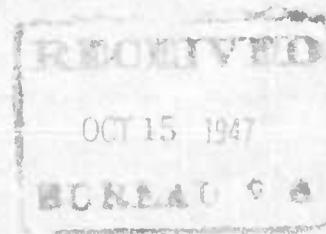
23. SIGNATURE

Medical Examiner
Cecil County

Address

M. D. or other

Oct. 15 1947



STATE OF MARYLAND—CERTIFICATE OF DEATH

596

08985

Registration Dist. No.

St. Ward

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County *Cecil*Village or City *Warwick*

No.

Length of residence in city or town where death occurred *78* yrs. *—* mos. *—* ds. How long in U. S. if of foreign birth? *—* yrs. *—* mos. *—* ds.2. FULL NAME *Henrietta Smith*(a) Residence: No. *Warwick* *nd*

If U. S. Veteran, specify WAR

St. *—* Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

*Black*5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)*Widowed*

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Wm Smith*

6. DATE OF BIRTH (month, day, and year)

April 18 - 1865

7. AGE

82

Years

6

Months

1

Days

—

If LESS than

1 day, *—* hrs.
or *—* min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.*Home*9. Industry or business in which
work was done, as STICK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

Nicomico Co -

(State or country)

Maryland

MOTHER FATHER

13. NAME *Don't know - has no record*

14. BIRTHPLACE (city or town)

(State or country)

Maryland

15. MAIDEN NAME

Gladys Perkins

16. BIRTHPLACE (city or town)

(State or country)

Maryland

17. INFORMANT

Katie Briscoe

(Address)

18. BURIAL, CREMATION, OR REMOVAL

*Cecilian Cemetery*Date *10-21*, 19*47*

19. UNDERTAKER

G. L. Warwick

(Address)

20. FILED

Oct 21, 1947 Mrs. Harold W. Lewis

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

October 19"

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY. That I attended deceased from

*June 22, 1941, to Oct 19", 1947*I last saw her *—* alive on *Sept 16", 1947*; death is said
to have occurred on the date stated above, et. *9:00* a.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:*Surf Arteric Sclerosis
Hyper Tension*Date of onset
*year
years*

Other Contributory Causes of importance:

*Arthritis*Name of operation *—* Date of *—*What test confirmed diagnosis? *—* Was there an autopsy? *—*

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? *—* Date of injury *—*, 19*—*

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury *—*Nature of injury *—*24. Was disease or injury in any way related to occupation of deceased? *no*If so, specify *—**Dorsey W. Lewis* M. D.
(Signed) *—* (Address) *Middleton - Del.*

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example II

The principal cause of death and related causes of importance were as follows:

<u>Arteriosclerosis</u>	1915
<u>Chronic interstitial nephritis</u>	1921
<u>Cerebral hemorrhage</u>	<i>July 5, 192</i>

Digitized by srujanika@gmail.com

Other contributory causes of importance:	
<u>Gallstones</u>	<u>May 1, 192</u>

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	OCT 24 1947	1 week ago
Run over by street car		1 week ago
Peritonitis		3 days ago

3 days ago

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08986

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... CECIL

City or town..... PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

23 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

VAH, Perry Point, Maryland

How long in hospital or Institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND

County..... BALTIMORE

City or town..... BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 208 Ridge Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

3.(a) FULL NAME

REGINALD STEMBRIDGE, JR.

3.(b) Social Security Number

216-01-8885

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife.....

Alice Stembridge

7. Birth date of decease (mo., day, yr.)

May 20, 1892

6.(c) If alive, give age..... years

8. AGE:

Years
55Months
4Days
15If less than one day
hrs. min.

B. Birthplace.....

Cheshire, England

(Town, county, and state)

10. Usual occupation.....

Salesman

11. Industry or business

MOTHER FATHER

Unknown

13. Birthplace

Unknown

14. Maiden name.....

Unknown

15. Birthplace

Unknown

16. Informant.....

Hospital Records

Address

VAH, Perry Point, Md.

17. Removal.....

Date thereof..... October 16, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Prospect Hills

Cemetery or crematory

Location

Towson, Maryland

18. Funeral director.....

JOHN BURNS SONS

Address

Towson, Maryland

19. Date rec'd by registrar.....

Oct. 16

1947

Irene E. Langford

Registrar

23. SIGNATURE.....

V.J. COVALESKY, M.D., Acting Director

10-16-47

Address..... VAH, Perry Point, Md. Date signed.....

I

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 15

1947, at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 22 1947 to October 15 1947

and that I last saw him alive on October 15 1947

Immediate cause of death

Chronic myocarditis and myocardial degeneration

Due to..... Coronary arteriosclerosis

DURATION

Unknown

Due to.....

Other condition..... Diffuse fibronous pleurisy; generalized arteriosclerosis

Unknown

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results..... Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

J. Canales

RECEIVED

OCT 17 1947

BUREAU 98

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68987

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 3 days

3. (a) FULL NAME

Rachel H. Welch

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female wife married

6. (b) Name of husband or wife: Patrick Welch

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age _____ years

About 1883

8. AGE:

Years

Months

Days

If less than one day

about 64

—

—

hrs. min.

9. Birthplace.....

(Town, county, and state)

North East Md

10. Usual occupation.....

Housewife

11. Industry or business

12. Name.....

no

MOTHER FATHER

13. Birthplace.....

no

14. Maiden name.....

my

15. Birthplace.....

formation

16. Informant.....

Hospital Records

Address

17. Burial (Burial, cremation, or removal, which?)

Burial Date thereof Oct 14-1947

(month) (day) (year)

Cemetery or crematory

Methodist

Location

North East Md

18. Funeral director.....

Joseph R. Frazer

Address

North East Md

19. (Date rec'd by registrar)

Oct 13 1947

R. Frazer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town North East (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 10 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 7 1947 to Oct 10 1947

and that I last saw her alive on Oct 9 1947

Immediate cause of death Diabetes, coma

Due to Diabetes mellitus unknown

Due to Chronic arteriosclerotic nephritis unknown

Other conditions Diabetes

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

G. A. M. D. M. D. M. D. or other

Address

Elkton Md

Date signed Oct 10 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

68988

Reg. Dist. No. 96

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Cecil
 City or town VAH, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year, 8 Mos., 7 days

Hospital, institution, or street address where death occurred:

Veterans Hospital, Perry Point, Md.How long in hospital or institution? 1 Yr., 8 Mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City City

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2823 Lafayette Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

James WILLIAMS3. (b) Social Security Number
Unknown

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWhiteSingle

6.(b) Name of husband or wife

6.(c) If alive, give age

years

7. Birth date of deceased (mo. day, yr.) March 5, 18878. AGE: Years 60 Months 7 Days 26 If less than one day

hrs. min.

9. Birthplace Baltimore, Md., Baltimore County

(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business

12. Name James Williams Sr.13. Birthplace New York14. Maiden name Adele Laplatte15. Birthplace Canada16. Informant Hospital Records

Address

17. Removal Removal Date thereof Oct. 28, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Flannery Cathedral Cem.Location Baltimore, Md.18. Funeral director Flannery & FlemingAddress 1426 Light St., Balto., Md.19. Date rec'd by registrar Oct. 28, 1947

(Date rec'd by registrar)

Signature James E. EdgingtonAddress 1426 Light St., Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28,

1947

at 3:55P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death Coronary occlusion

19.....

Due to coronary sclerosis

DURATION

10 Min.

Due to

Other conditions Arteriosclerosis, generalized, coronary sclerosis, diverticulitis of ileum, adenoma, adrenal, right. Nephrosclerosis

Major findings of operations

Date of op.

Autopsy results See above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

Medical Examiner

for Cecil County

M. D. or other

Date signed

Address

Date signed

RECEIVED

OCT 31 1947

BUREAU